Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 30, 2015

Mr. Daniel Daly,
The Residence At Shelburne Bay East
185 Pine Haven Shores Road
Shelburne, VT 05482-7805

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 25, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 04/06/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1009	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY EAST	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site survey was completed by staff from the Vermont Division of Licensing and Protection on 3/25/15 to investigate 3 facility mandatory self-reports and a complaint. The following are regulatory violations.	R100		
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure the provision of care to meet each resident's medical and personal care needs for 1 of 6 residents in the total sample. (Resident #2). Findings include: Per record review on 3/24/15, Resident #2 had a history of recurrent urinary tract infections (UTIs) and a physician order dated 2/4/15 ordered timed toileting every 2 hours while awake, to help prevent further UTIs due to infrequent toileting. During interview on 3/25/15 at 10 AM, the resident confirmed that the physician wanted him/her to empty the bladder at least every 2 hours while awake daily. The resident stated that staff do not always come to the room to provide the assistance needed on a timely basis. The resident said if he/she did not ring for assistance,	R126	R126 - Resident Care and Home services (5.5 General Care) The Resident Care Associates (RCA's) were re-educated about the toileting plan for resident #2. Assignment sheets, which delineate toileting plans for caregivers, were audited for accuracy by the nurses. When residents are placed on toileting plans, the nurse will ensure that the staff are educated about the toileting schedule change and the toileting plan will be included on the RCA assignment sheet Care plans and assignments sheets will be reviewed for accuracy to ensure the caregivers' assignment sheets reflect current plan of care.	4/24/15

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 4/14/15

STATE FORM 6899 D82D11 If continuation sheet 1 of 5

R126 - R200 POC accepted 4/28/15 mBoltonRN/PMC

PRINTED: 04/06/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1009	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY EAST	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R126	Continued From page 1 staff would not come to assist them every 2 hours, as ordered and stated in the plan of care. Per review of the resident's comprehensive nursing assessment (6/20/14) and the current care plan, the resident required standby assistance for completion of activities of daily living, including ambulation and transfers. The resident also has a history of falls and significant joint disease. The care plan states "the resident is on every 2 hour toileting plan per urologist". Staff need to anticipate and arrive to assist the resident in order to successfully adhere to the plan as stated and ordered by the urologist. Staff's failure to consistently provide this toileting assistance as ordered, and as needed, was confirmed during interview with the Administrator on 3/25/15 at 5 PM.	R126	R178 – Resident Care and Home Services (5.11 Staff Services) The community has a policy and procedure for elopement, see attached Resident Elopement and Response Procedure. All associates will be educated to this policy and procedure. Elopement Drills will be held at least quarterly. See attached Missing Resident Drill Checklist. Resident #1, upon return to the community is currently residing in the secure memory care unit. All new Care Associates will be educated to the policy and procedure to follow in the event of an elopement. This inservice will also be scheduled at least annually as part of the yearly inservices.	
R178 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that all staff in charge of the units were trained in procedures regarding a resident elopement, to assure prompt actions to protect the health and safety of all residents at risk. One of 6 residents reviewed was affected by the deficient practice. (Resident #1). Findings	R178		4/24/15

PRINTED: 04/06/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1009	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY EAST	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R178	Continued From page 2 include: Per review of a mandated self-report of a resident elopement on 3/20/15 and confirmed during interview with the Administrator (ADM) and the Director of Nurses (DNS) on 3/24/15 at 12:20 PM, the facility failed to have available a written policy and procedure to direct staff actions in the case of a resident elopement from the facility. Per the records reviewed, the resident was missing from their room at 4:20 PM and 5:30 PM on 3/20/15. The resident had not signed out that he/she was leaving the grounds that day. The Medication Technician (MT) in charge at this time of day called the day shift charge nurse at home (she had left the facility after her shift was finished) and informed her that Resident #1 was not in his/her room when checked at 5:30. P.M. The Licensed Practical Nurse (LPN) instructed the staff person to call the DNS and the ADM and begin a search for the resident, room by room, per interview with the DNS at 10:30 AM on 3/24/15. The MT directed staff to conduct the room searches immediately but did not call the ADM or DNS until 7:30 P.M., a full 2 hours after discovery that the resident was missing. The resident was ultimately located and returned to the facility the following day, over 24 hours after they were noted as missing. The resident was not able to fully explain their absence from the facility during the hours that they were missing and there were no noted changes in condition. Although one LPN interviewed during the day shift of 3/24/15 stated that when any unusual event occurs, staff are supposed to notify the ADM and DNS right away, there was no written policy regarding this process. During interview (as noted above), the DNS also acknowledged that unlicensed staff who are in charge after the	R178		

PRINTED: 04/06/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1009	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY EAST	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R178	Continued From page 3 nurses have left for the day have received no training in how to proceed in the case of a resident elopement and there is no written policy/procedure to direct them. Refer also to R200.	R178		
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have a written policy and procedure to direct staff actions in case of a resident elopement for 1 applicable resident of the total sample of 6 residents. (Resident #1). Findings include: Per review of a mandated self-report of a resident elopement on 3/20/15 and confirmed during interview with the Administrator (ADM) and the Director of Nurses (DNS) on 3/24/15 at 12:20 PM, the facility failed to have available a written policy and procedure to direct staff actions in the case of a resident elopement from the facility. Per the records reviewed, the resident was missing from their room at 4:20 PM and 5:30 PM on 3/20/15. The resident had not signed out that he/she was leaving the grounds that day. The Medication Technician (MT) in charge at this time of day called the day shift charge nurse at	R200	R200 – Resident Care and Home Services (5.15 Policies and Procedures) The community has a policy and procedure for elopement, see attached Resident Elopement and Response Procedure. All associates will be educated to this policy and procedure. Elopement Drills will be held at least quarterly. See attached Missing Resident Drill Checklist. Policy and Procedures will be available to staff in common areas for review should an emergency arise. Staff will be educated on location of the binders and how they are organized.	4/24/15

PRINTED: 04/06/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1009	A. BUILDING: _____ B. WING _____	C 03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY EAST	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R200	Continued From page 4 home (she had left the facility after her shift was finished) and informed her that Resident #1 was not in his/her room when checked at 5:30. P.M. The Licensed Practical Nurse (LPN) instructed the staff person to call the DNS and the ADM and begin a search for the resident, room by room, per interview with the DNS at 10:30 AM on 3/241/5. The MT directed staff to conduct the room searches immediately but did not call the ADM or DNS until 7:30 P.M., a full 2 hours after discovery that the resident was missing. The resident was ultimately located and returned to the facility the following day, over 24 hours after they were noted as missing. The resident was not able to fully explain their absence from the facility during the hours that they were missing and there were no noted changes in condition. Although one LPN interviewed during the day shift of 3/24/15 stated that when any unusual event occurs, staff are supposed to notify the ADM and DNS right away, there was no written policy regarding this process. During interview (as noted above), the DNS also acknowledged that unlicensed staff who are in charge after the nurses have left for the day have received no training in how to proceed in the case of a resident elopement and there is no written policy/procedure to direct them. Refer also to R178.	R200		

Resident Elopement Response Procedure	
Action – Upon Identifying a Possible Elopement	**Check-Off**
Executive Director to designate staff on each shift for elopement response as leader	
Each shift Assisted Living and Special Care designate a leader in charge for handling the steps of an elopement response. (Executive Director days, Manager on Duty weekends, specific Resident Care Assistants/Nurses for evenings and nights.	
Immediately	
Immediately go to each exit open the door (including courtyard) and look left and right for resident.	
Conduct an In-house search. Contact Executive Director. Check the communication log to see if resident is out with family, etc. Check each and every room in the Special Care Unit and Assisted Living. Leader to coordinate locations for staff to search (ex. If special care resident, begin in special care. Assign individuals to search and not in teams.) All individuals involved in search report efforts to leader. **If resident is not located notify police immediately.** SPECIAL CARE • Every resident room/closets/bathroom beds ____ • Public restrooms on special care unit ____ • Dining area ____ • Activity area ____ • Closet/storage areas ____ • Offices ____ ASSISTED LIVING • Every resident room ____ • Dining area ____ • All activity areas ____ • Kitchen area ____ • Staff Break room ____ • Restrooms ____ • Closet Storage areas ____ • Offices ____ • Café Bistro ____ • Library ____ (If Assisted Living, Executive Director/ designee to contact family and ensure resident has not returned to home or friends, etc.)	
Conduct an outside search. Leader to coordinate locations for staff to search. Check the entire grounds. Look in all directions during search (Depending on building layout-plan which areas will be checked first.) Report to Leader after search. • Perimeter of building ____ • Scan cars in the parking lot ____ • Perimeter of parking lot ____ • Mechanical/sprinkler riser rooms ____ • Parking lot ____ • Sheds on Property ____ • Nearest exit road from community ____	

Review the Visitor sign in log (implement immediately a visitor/resident sign in/out policy.)	
Review Dining log (implement, as appropriate, a community designee to count number of residents during each meal service.)	
Within one hour – Executive Director/Resident Care Director/Special Care Director. Executive Director/Resident Care Director/Special Care Director takes over response.	
Notify Police	
Notify Responsible Party	
Notify physician	
Notify Regional Executive Director	
Notify Director of Assisted Living	
Notify Police	
Plan periodic/daily conference calls for updates with Regional Executive Director and Director of Assisted Living until location of resident is known.	
Action - Resident is found	
Executive Director/Resident Care Director/Special Care Director Immediately ascertain condition of resident	
The resident's mental or physical health or behavior is reviewed and determined if hospitalization is needed. Complete an assessment.	
All contacts made during the search are re-contacted to announce the resident's return.	
Review measures needed to protect the resident. It may be necessary to bring in additional staff or employ agency personnel to stay with the resident.	
Action – Post Incident Review of How Elopement Occurred	**Comments**
Special Care – Physical plant and equipment check. Test all doors for locking and alarm, windows, staff pagers, courtyard gate for malfunctions. Place work orders as needed. If equipment malfunction occurred, discuss a plan for keeping residents safe.	
Assisted Living – Review front desk procedures and meal time counts	
Discuss incident with family and physician on resident's current treatment regime.	
Special Care/Assisted Living – Review resident's behaviors and actions for the prior 24 hours leading up to the incident.	
Review directors and staffs response to the incident.	
In-service staff on any areas needing improvement.	

Missing Resident

POLICY

It is the policy of LCB Senior Living to ensure that a plan is immediately initiated in the event a resident is found missing from the Community.

PROCEDURE

In the event a staff member has determined a resident has not appeared for mealtime or a scheduled event or cannot be located, the following procedures should be implemented.

1. The sign in/out log should be checked to determine whether the resident has indicated plans to leave the community.

2. If a resident fails to attend a meal (Meal Attendance Policy), or has not signed out, a phone call should be placed to the apartment. If there is no answer, an apartment check will be done.

3. If the resident is not located, the Executive Director/Designee should be notified immediately.

4. The Executive Director/Designee should assign each employee a specific area to search. Areas should include all common areas, storage areas, halls, kitchen activity areas, lounges, bathrooms, and stairways. It is important to open all closets and doors and examine the area to assure the resident is not hiding, injured or asleep in one of these areas. The grounds of the community shall be thoroughly searched.

5. If the resident has not been found after an intensive search of the Community, all rooms, spaces therein and the grounds, family should be notified and the police should be contacted.

6. The Executive Director/Designee should assemble a team to search the surrounding neighborhood.

7. A call must be made to the licensing agency as required by state regulations. (See state regulations for reporting procedures).

8. Notify appropriate agency/association to initiate their search procedure.

9. If the Resident is registered with the Alzheimer's Association Safe Return Program, the national hotline number should be called: 800-572-1122. Be prepared to provide the Residents Safe Return Registration Identification Number.

10. Notify Department Heads to assist in the search procedure.

11. Notify LCB Senior Living, LLC management staff. LCB designee will speak with media if necessary (see dealing with the media). Any telephone inquiry from a newspaper or radio station should be directed to the Executive Director/Designee.

AFTER THE RESIDENT HAS BEEN FOUND, THE FOLLOWING STEPS SHOULD BE TAKEN:

1. When resident is found, determine resident's immediate needs, an M.D. visit may be recommended for evaluation.

2. Notify search team family and other above agencies.

3. Implement hourly status checks to supervise the resident over the 24 hour period after the incident has occurred. Status checks will be documented on a written check sheet.

4. Document in the Resident's record, the details of the event including the following information:

   a. Condition of the Resident prior to the Incident.

   b. Time Resident was discovered missing.

   c. Last time Resident had been seen.

   d. Complete description of the search effort, including notification of employees, authorities, family, etc.

   e. Time the Resident was found.

   f. Place Resident was found.

   g. Findings of the RSD regarding Resident's physical and mental status upon return.

   h. Details regarding the manner in which the event occurred.

   i. Document notification of the physician and family, as well as state agencies and police as required.

   j. Any further information that may prevent a recurrence.

5. The Executive Director/Designee shall hold a meeting with all managers and staff involved to reassess the process and search procedures used.

6. Complete Incident Report, any state required forms/reports required by law.

7. Notify Licensing agency of Resident status.

RESIDENT REASSESSMENT REQUIRED/MISSING RESIDENT:

1. The RSD/Designee should assess the Resident following the incident and discuss with the Executive Director to determine if Resident's needs can still be met in the Community.

2. The RSD/Designee should consult with the LCB in determining that appropriate medical evaluations and interventions are provided determining whether this was an isolated occurrence or if it is likely to be repeated and compromise the Resident's safety and welfare.

3. The Resident should also be evaluated by his/her physician within a reasonable time frame as determined by circumstances and physician availability.

4. If the determination is made that the Resident's needs can no longer be met, a 30-day notice (or State required notice) terminating the residency agreement must be delivered to the Resident and Resident's responsible person(s).

5. During the 30-day (or State specific period) that this resident is no longer appropriate for residency, the family and/or responsible person(s) will be responsible for placing a private sitter with the Resident to ensure the safety of the Resident until his/her discharge.

MISSING RESIDENT DRILL CHECKLIST

Community Name:

YES	NO	N/A	ITEM	COMMENTS	INITIALS	DATE
			Is the policy and procedures for missing person easily accessible?			
			Do your procedures include a search protocol and is it reviewed and updated annually?			
			Do you have a list of people to call in the event of a missing person (i.e. local authorities, LCB and family members)? Is it reviewed and updated annually?			
			Do you know what to do if contacted by the press?			
			Do associates know their responsibilities if a resident is found missing?			
			Are the residents who have the potential to elope identified?			
			Do you maintain a log of when residents leave the building (date, time, with whom)? Are families aware of this procedure?			
			Do you have recent photos of the residences who are at high risk? Do you have consent to photograph?			
			Do associates know where the photographs are located for quick access?			
			Are supply closets, utility room doors locked?			
			Are the exterior doors locked at night? If the doors have a locking system, are they in compliance with fire safety regulations?			
			In Reflections, are exit doors alarmed and secured? Are alarms tested and documented at least monthly?			
			In Reflections, are doors checked each shift?			
			In Reflections, are exits that are not alarmed in clear view of the staff?			
			Are missing resident drills conducted periodically?			